ASSEMBLY, No. 2420

STATE OF NEW JERSEY

INTRODUCED OCTOBER 7, 1996

By Assemblywoman VANDERVALK

AN ACT concerning patient protections under health benefits plans, supplementing Titles 26 and 17 of the Revised Statutes and Title 17B of the New Jersey Statutes and amending P.L.1973, c.337.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. This act shall be known and may be cited as the "Health Care Quality Act."

2. (New section) As used in sections 2 through 11 of this act:

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State.

"Commissioner" means the Commissioner of Health and Senior Services.

"Covered person" means a person on whose behalf a carrier or other entity offering the plan is obligated to pay benefits pursuant to the health benefits plan.

"Covered service" means a health care service provided to a covered person under a health benefits plan for which the carrier or other entity offering the plan is obligated to pay benefits.

"Department" means the Department of Health and Senior Services.

"Health benefits plan" means a benefits plan which pays hospital and medical expense benefits for covered services and is delivered or issued for delivery in this State by or through a carrier or any other entity. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, Medicare supplement coverage, CHAMPUS supplement coverage, coverage for Medicare services pursuant to a contract with the United States government, coverage for Medicaid services pursuant to a contract with the State, coverage arising out of a workers' compensation or similar law, automobile

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) or hospital confinement indemnity coverage.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health benefits plan. Health care provider includes, but is not limited to, a physician and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

"Managed care plan" means a health benefits plan that integrates the financing and delivery of appropriate health care services to covered persons by arrangements with participating providers, who are selected to participate on the basis of explicit standards, to furnish a comprehensive set of health care services and financial incentives for covered persons to use the participating providers and procedures provided for in the plan. A managed care plan may be issued by or through a carrier which assumes financial risk for the plan or any other entity that provides and finances health benefits for a covered person.

"Network contractor" means an entity that enters into a contractual arrangement with a health care provider to form a network of providers to deliver a comprehensive package of health care services, which includes hospital and medical services, to residents of this State and contracts with a payer for access to the network for the payer's managed care plan. A network contractor does not assume financial risk for the health care services provided by the network for a managed care plan. A network contractor may contract with payers to provide utilization management and quality assurance programs and other related services. Network contractor shall not include an entity that operates under an exclusive contract with one or more health maintenance organizations which hold a certificate of authority pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.).

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system may include: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.

3. (New section) a. A managed care plan in effect on the effective date of this act which provides benefits to residents of this State shall file a registration form with the department within 90 days of the

effective date of this act. A managed care plan established after the effective date of this act or for which corporate ownership changes after the effective date of this act shall file a registration form with the department at least 30 days prior to the date the plan will begin to provide benefits to residents of this State. The registration form shall be valid for two years, but the managed care plan shall notify the department within 10 business days of any change in information provided on the registration form.

b. A carrier which offers an individual or group health benefits plan to residents of this State on an indemnity basis on the effective date of this act shall file a registration form with the department within 90 days of the effective date of this act. A carrier authorized to issue health benefits plans in this State after the effective date of this act or for which corporate ownership changes after the effective date of this act shall file a registration form with the department at least 30 days prior to the date the carrier will begin to offer a health benefits plan to residents of this State. The registration form shall be valid for two years, but the carrier shall notify the department within 10 business days of any change in information provided on the registration form.

c. A network contractor in operation on the effective date of this act shall file a registration form with the department within 90 days of the effective date of this act. A network contractor established after the effective date of this act or for which corporate ownership changes after the effective date of this act shall file a registration form with the department at least 30 days prior to the date the entity will begin to offer its services in this State. The registration form shall be valid for two years, but the network contractor shall notify the department within 10 business days of any change in information provided on the registration form.

d. The commissioner shall establish a registration form for managed care plans, indemnity carriers and network contractors which shall request, at a minimum, the official address and telephone number of the place of business of the managed care plan, carrier or network contractor.

e. The filing of a registration form by a managed care plan, indemnity carrier or network contractor with the department pursuant to this act is for informational purposes only in order to enable the department to carry out the provisions of this act. The registration required pursuant to this act shall not be construed to authorize the department to regulate managed care plans, carriers or network contractors in any manner not otherwise provided by law.

f. A managed care plan, indemnity carrier or network contractor filing a registration form with the department pursuant to this act shall pay a biennial registration fee of $200.

g. A health maintenance organization which holds a certificate of authority pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) shall be

exempt from the registration requirements of this section but shall comply with the provisions of sections 2 and 4 through 21 of this act.

A health maintenance organization shall be required to comply with the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.) and any rules and regulations adopted pursuant thereto, except that in the event that the provisions of this act conflict with the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.), the provisions of this act shall supercede the provisions of P.L.1973, c.337

h. A carrier which issues health benefit plans utilizing a selective contracting arrangement pursuant to section 22 of P.L.1993, c.162 (C.17B:27A-54) shall be exempt from the registration requirements of this section with respect to the selective contracting arrangement, but shall comply with the provisions of sections 2 and 4 through 21 of this act.

A carrier shall be required to comply with the provisions of section 22 of P.L.1993, c.162 (C.17B:27A-54) and any rules and regulations adopted pursuant thereto, except that in the event that the provisions of this act conflict with the provisions of section 22 of P.L.1993, c.162 (C.17B:27A-54), the provisions of this act shall supercede the provisions of P.L.1993, c.162.

4. (New section) A managed care plan or indemnity carrier, as appropriate, shall disclose in writing, in easily understandable language, to a subscriber, insured or enrollee, as the case may be, the terms and conditions of its health benefits plan, and shall promptly provide the subscriber, insured or enrollee with written notification of any change in the terms and conditions prior to the effective date of the change. The managed care plan or indemnity carrier shall provide the required information at the time of enrollment and annually thereafter.

a. The information required to be disclosed pursuant to this section shall include a description of:

(1) covered services and benefits to which the covered person is entitled;

(2) treatment policies and restrictions or limitations on covered services and benefits, including, but not limited to, physical and occupational therapy services, clinical laboratory tests, hospital and surgical procedures, prescription drugs and biologics, radiological examinations and behavioral health services;

(3) financial responsibility of the covered person, including copayments and deductibles;

(4) prior authorization and any other review requirements with respect to accessing covered services;

(5) where and in what manner covered services may be obtained;

(6) changes in covered benefits, including any addition, reduction or elimination of specific benefits;

(7) the covered person's right to appeal and the procedure for initiating an appeal of a utilization management decision made by or on behalf of the managed care plan or carrier with respect to the denial, reduction or termination of a covered health care benefit or the denial of payment for a health care service;

(8) the procedure to initiate an appeal pursuant to the provisions of P.L., c. (C.)(pending before the Legislature as Senate Bill No. 266 of 1996); and

(9) such other information as the commissioner shall require.

b. The carrier or managed care plan shall file the information required pursuant to this section with the department.

5. (New section) a. In addition to the disclosure requirements provided in section 4 of this act, a managed care plan shall disclose to a prospective subscriber, insured or enrollee, as the case may be, in writing, in easily understandable language, the following information:

(1) A participating provider directory providing information on a covered person's access to primary care physicians and specialists, including the number of available participating physicians, by provider category or specialty, and their professional office addresses. The managed care plan shall promptly notify a subscriber, insured or enrollee, who is affected, of any changes in the list of primary care physicians;

(2) General information about the financial incentives between participating physicians under contract with the managed care plan or network contractor, as applicable, and other participating health care providers and facilities to which the participating physicians refer their managed care patients;

(3) The percentage of the managed care plan's network physicians who are board certified; and

(4) The managed care plan's standard for customary waiting times for appointments for urgent and routine care.

The managed care plan shall provide the information required in this subsection at the time of enrollment and annually thereafter.

b. Upon request of a covered person, a managed care plan shall promptly inform the person:

(1) whether a particular network physician is board certified; and

(2) whether a particular network physician is currently accepting new patients.

c. The managed care plan shall file the information required pursuant to this section with the department.

6. (New section) a. A managed care plan shall designate a licensed physician to serve as medical director of the plan. The medical director, or his designee, shall be designated to serve as the medical director for medical services provided to the managed care

plan's covered persons in the State and shall be licensed to practice medicine in New Jersey.

The medical director shall be responsible for treatment policies, protocols, quality assurance activities and utilization management decisions of the plan. The treatment policies, protocols, quality assurance program and utilization management decisions of the plan shall be based on nationally recognized standards of health care practice. The quality assurance and utilization management programs shall be in accordance with standards adopted by regulation of the department pursuant to this act.

b. A network contractor shall maintain quality assurance and utilization management programs for the network. The quality assurance and utilization management programs shall be in accordance with standards adopted by regulation of the department pursuant to this act. The network contractor may contract with a payer for use of the quality assurance and utilization management programs for the payer's managed care plan.

The network contractor shall designate a licensed physician to serve as medical director of the network. The medical director, or his designee, shall be designated to serve as the medical director for medical services provided by the network to covered persons in the State and shall be licensed to practice medicine in New Jersey. The medical director shall be responsible for quality assurance activities and utilization management decisions of the network. The quality assurance activities and utilization management decisions shall be based on nationally recognized standards of health care practice.

c. The medical director of the plan or network shall ensure that:

(1) Any utilization management decision to deny, reduce or terminate a health care benefit or to deny payment for a health care service, because that service is not medically necessary, shall be made by a physician with knowledge in the area of the health care practice. In the case of a health care service prescribed or provided by a dentist, the decision shall be made by a dentist with knowledge in the area of the health care practice;

(2) A utilization management decision shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the plan or network, as appropriate, for those services, unless the approval was based upon fraudulent information submitted by the covered person or the participating provider;

(3) A procedure is implemented whereby participating physicians and dentists have an opportunity to review and comment on all medical and surgical and dental protocols, respectively, of the plan; and

(4) The utilization management program is available on a 24-hour basis to respond to authorization requests for emergency services and

is available, at a minimum, during normal working hours for inquiries and authorization requests for nonemergency health care services.

7. (New section) Each application for credentialing or participation, as appropriate, to a managed care plan or network contractor shall be reviewed by a committee of the plan or contractor that includes appropriate representation of health care professionals with knowledge in the applicant's scope of professional practice.

8. (New section) A managed care plan or network contractor shall establish a policy governing removal of health care providers from the plan or network which includes the following:

a. The plan or contractor shall inform all participating health care providers of the plan's or contractor's removal policy at the time the plan or contractor contracts with the health care providers to participate in the plan or network, and at each renewal thereof.

b. If a health care provider's credentialing will be withdrawn or participation terminated prior to the date of termination of the contract, the plan or contractor shall provide the provider with 90-days notice of the withdrawal or termination, unless the withdrawal or termination is for breach of contract or because, in the opinion of the medical director, the health care provider represents an imminent danger to an individual patient or to the public health, safety or welfare.

A plan or contractor shall not terminate a contract with a provider unless the plan or contractor provides the provider with written notice of the reasons for termination.

Any challenge brought by a provider to his termination shall be subject to a binding alternative dispute resolution process conducted by a neutral and professional arbitration service selected either by the plan or contractor or under the terms of the provider's contract with the plan or contractor. The costs of conducting the alternative dispute resolution process shall be borne by the provider unless the arbitration service determines that the termination was made in bad faith.

c. If the plan or contractor finds that a health care provider represents an imminent danger to an individual patient or to the public health, safety or welfare, the plan or contractor shall promptly notify the appropriate professional State licensing board or State licensing authority, as appropriate.

9. (New section) A managed care plan's or network contractor's contract with a participating health care provider:

a. Shall state that the health care provider shall not be penalized or the contract terminated by the managed care plan or network contractor because the health care provider acts as an advocate for the patient in seeking appropriate, medically necessary covered health care

services;

b. Shall not provide financial incentives to the health care provider for withholding covered health care services that are medically necessary, in the opinion of the medical director; and

c. Shall protect the ability of a health care provider to communicate openly with a patient about all appropriate diagnostic testing and treatment options.

10. (New section) a. A managed care plan shall offer a point-of-service plan option rider to every policy or contract holder which would allow a covered person to receive covered health care benefits from out-of-network providers without having to obtain a referral or prior authorization from the managed care plan. The point-of-service plan option may require that a covered person pay a higher deductible or copayment and higher premium for the plan option, pursuant to limits established by the department by regulation.

b. A managed care plan shall provide each covered person in a plan whose policy or contract holder elects the point-of-service plan option, with the opportunity, at the time of enrollment and during the annual open enrollment period, to enroll in the point-of-service plan option. The managed care plan shall provide written notice of the point-of-service plan option to each covered person in a plan whose policy or contract holder elects the point-of-service option and shall include in that notice a detailed explanation of the financial costs to be incurred by a covered person who selects that plan option.

c. The requirements of this section shall not apply to a managed care plan which only provides health care services to Medicaid recipients pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), or a managed care plan which has been in operation for less than three years.

11. (New section) A managed care plan, indemnity carrier or network contractor that violates any provision of this act shall be liable to a civil penalty of not less than $250 and not greater than $10,000 for each day the plan, carrier or contractor is in violation of the act if reasonable notice in writing is given of the intent to levy the penalty and the managed care plan, indemnity carrier or network contractor has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation, and fails to do so within the time allowed. The penalty shall be collected by the commissioner in the name of the State in a summary proceeding in accordance with "the penalty enforcement law," N.J.S.2A:58-1 et seq.

12. (New section) The commissioner shall enforce the provisions of this act and adopt rules and regulations, pursuant to the

"Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), necessary to carry out the provisions of this act.

13. (New section) Notwithstanding the provisions of chapter 26 of Title 17B of the New Jersey Statutes to the contrary, no policy shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

14. (New section) Notwithstanding the provisions of chapter 27 of Title 17B of the New Jersey Statutes to the contrary, no policy shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

15. (New section) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, no policy or contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy or contract meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

16. (New section) Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) to the contrary, no policy or contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the policy or contract meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

17. (New section) Notwithstanding the provisions of P.L.1938, c.366 (C.17:48-1 et seq.) to the contrary, no individual or group contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the contract meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

18. (New section) Notwithstanding the provisions of P.L.1940, c.74 (C.17:48A-1 et seq.) to the contrary, no individual or group contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the contract meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

19. (New section) Notwithstanding the provisions of P.L.1985, c.236 (C.17:48E-1 et seq.) to the contrary, no individual or group contract shall be delivered, issued, executed or renewed on or after the effective date of this act unless the contract meets the requirements of P.L. , c. (C.)(pending before the Legislature as this bill).

20. (New section) Notwithstanding the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.) to the contrary, a certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued on or after the effective date of this act unless the health maintenance organization meets the requirements of P.L. , c. (C.) (pending before the Legislature as this bill).

21. Section 24 of P.L.1973, c.337 (C.26:2J-24) is amended to read as follows:

24. a. The commissioner may, in lieu of suspension or revocation of a certificate of authority under section 18 hereof, levy an administrative penalty in an amount not less than **[**$100.00**]** $250 nor more than**[**$1,000.00**]** $10,000 for each day the health maintenance organization is in violation of P.L.1973, c.337 (C.26:2J-1 et seq.), if reasonable notice in writing is given of the intent to levy the penalty **[**and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation, and fails to do so within said time**]** and the health maintenance organization has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the defect in its operations which gave rise to the penalty citation, and fails to do so within the time allowed. Any such penalty may be recovered in a summary proceeding pursuant to **[**the Penalty Enforcement Law (N.J.S.2A:58-1 et seq.)**]** "the penalty enforcement law," N.J.S.2A:58-1 et seq.

b. Any person who violates this act is a disorderly person and shall be prosecuted and punished pursuant to the "disorderly persons law" subtitle 12 of Title 2A of the New Jersey Statutes.

c. (1) If the commissioner or the Commissioner of Insurance shall for any reason have cause to believe that any violation of this act has occurred or is threatened, the commissioner or Commissioner of Insurance may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(2) Proceedings under this subsection c. shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner or the Commissioner of Insurance may deem appropriate under the circumstances.

d. (1) The commissioner or the Commissioner of Insurance may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist

from engaging in any act or practice in violation of the provisions of this act.

(2) Within 20 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this act have occurred. Such hearings shall be conducted pursuant to the Administrative Procedure Act, P.L.1968, c.410 (C.52:14B-1 et seq.) and judicial review shall be available as provided therein.

e. In the case of any violation of the provisions of this act, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection d. of this section, the commissioner may institute a proceeding to obtain injunctive relief, in accordance with the applicable Court Rules.

(cf: P.L.1973, c.337, s.24)

22. This act shall take effect on the 180th day after enactment.

STATEMENT

This bill, which is designated the "Health Care Quality Act," provides various consumer safeguards with respect to health insurance and the operation of managed care plans.

Specifically, the bill:

• requires managed care plans, indemnity carriers and network contractors (entities, such as preferred provider organizations or PPOs, that establish health care provider networks for managed care plans) to register with the Department of Health and Senior Services;

• requires managed care plans and indemnity carriers to disclose to covered persons, in writing, in easily understandable language, at the time of enrollment and annually thereafter, the terms and conditions of the health benefits plan, which information shall include a description of:

a. covered services and benefits to which the covered person is entitled;

b. treatment policies and restrictions or limitations on covered services and benefits, including, but not limited to, physical and occupational therapy services, clinical laboratory tests, hospital and surgical procedures, prescription drugs and biologics, radiological examinations and behavioral health services;

c. financial responsibility of the covered person, including copayments and deductibles;

d. prior authorization and any other review requirements with respect to accessing covered services;

e. where and in what manner services or benefits may be obtained;

f. changes in covered benefits, including any addition, reduction or elimination of specific benefits;

g. the covered person's right to appeal and the procedure for initiating an appeal of a utilization management decision made by or on behalf of the managed care plan or carrier with respect to the denial, reduction or termination of a covered health care benefit or the denial of payment for a health care service;

h. the procedure to initiate an appeal pursuant to the provisions of Senate Bill No. 266 of 1996 which establishes the Statewide Independent Health Benefits Plan Appeals Program in the Department of Health and Senior Services; and

i. such other information as the commissioner shall require.

• requires managed care plans to also disclose to a prospective covered person, in writing, in easily understandable language, the following information at the time of enrollment and annually thereafter:

a. a participating provider directory providing information on a covered person's access to primary care physicians and specialists, including the number of available participating physicians, by provider category or specialty, and their professional office addresses;

b. general information about the financial incentives between participating physicians under contract with the managed care plan and other participating health care providers and facilities to which the participating physicians refer their managed care patients;

c. The percentage of the managed care plan's network physicians who are board certified; and

d. The managed care plan's standard for customary waiting times for appointments for urgent and routine care.

Also, upon request of a covered person, a managed care plan shall promptly inform the person whether a particular network physician is board certified and whether a particular network physician is currently accepting new patients.

• requires managed care plans and network contractors to have a medical director who is a licensed physician and who is responsible for treatment policies, protocols, quality assurance activities and utilization management decisions of the plan, in the case of a managed care plan, and quality assurance activities and utilization management decisions, in the case of a network contractor. The medical director, or his designee, shall be a New Jersey licensed physician and shall be designated to serve as the medical director for medical services provided to covered persons in the State. Also, quality assurance and utilization management programs shall be in accordance with standards adopted by the Department of Health and Senior Services;

• requires network contractors to maintain quality assurance and utilization management programs and provides that the network contractor may contract with payers for use of the programs for their

managed care plans;

• requires managed care plans and network contractors to establish a policy governing the removal of health care providers which provides 90-days' notice for withdrawal of credentialing (if the withdrawal of credentialing occurs prior to the date of termination of the contract), unless there is a breach of contract or, in the opinion of the medical director, the health care provider represents an imminent danger to an individual patient or to the public health, safety or welfare;

• provides that a plan or contractor shall not terminate a contract with a provider unless the plan or contractor gives the provider written notice of the reasons for termination, and that any challenge brought by a provider to his termination shall be subject to a binding alternative dispute resolution process conducted by a neutral and professional arbitration service selected either by the plan or contractor or under the terms of the provider's contract with the plan or contractor;

• provides that a participating health care provider shall not be penalized or have his contract terminated because the health care provider acts as an advocate for the patient in seeking appropriate, medically necessary covered health care benefits, and prohibits any provision in a provider's contract that provides financial incentives for withholding covered health care services that are medically necessary, in the opinion of the medical director. Also, the contract shall protect the ability of a health care provider to communicate openly with a patient about all appropriate diagnostic testing and treatment options;

• requires a managed care plan to offer a point-of-service option rider to all policy or contract holders which would allow a covered person to receive covered health care benefits from out-of-network providers without having to obtain a referral or prior authorization from the managed care plan. The covered person may be required to pay a higher deductible or copayment and higher premium for the plan option; and

• provides that the penalty for violations of the bill shall be between $250 and $10,000 for each day the violation continues and increases the penalties in the law governing health maintenance organizations, P.L.1973, c.337, to these same amounts. The bill also provides that reasonable notice in writing be given to the managed care plan, network contractor, indemnity carrier or health maintenance organization of the intent to levy the penalty and the managed care plan, indemnity carrier, network contractor or health maintenance organization would have 30 days or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation.

Designated the "Health Care Quality Act.